OFFICE OF MINORITY AND MULTICULTURAL HEALTH

REQUEST FOR APPLICATIONS

COMMUNITY HEALTH MOBILIZATION GRANTS: REDUCING DIABETES DISPARITIES

NEW JERSEY DEPARTMENT of HEALTH and SENIOR SERVICES

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TABLE OF CONTENTS

OFFICE OF MINORITY AND MULTICULTURAL HEALTH
COMMUNITY HEALTH MOBILIZATION GRANTS:
REDUCING DIABETES DISPARITIES

I. PURPOSE OF FUNDING

The New Jersey Department of Health and Senior Services, Office of Minority and Multicultural Health (NJDHSS, OMMH) announces availability of funds for community and faith-based organizations to address health disparities in diabetes among African Americans, American Indians/Alaska Natives, Latinos/Hispanics, Asian Americans and Native Hawaiians/Pacific Islanders and all other persons disproportionately impacted by the disease in the State of New Jersey. Project activities under this RFA will focus on strategies to increase awareness about diabetes disparities, increase screening and identification of individuals living with the disease, and improve access to care and resources to improve management of the condition and its co-morbidities. This funding is intended to support intervention projects of community organizations which have experience in and the capability to implement programs which improve diabetes outcomes in minority communities.

A review of best practices in diabetes management nationwide reveals that a comprehensive intervention method which includes community level involvement, patient-provider interaction and peer counseling is essential. The intervention must be supported by community resources, self-management skill building, creativity in gaining access to care for disadvantaged persons, technical innovation, organizational support and a strong evaluation component. Key components of the diabetes grant program include health promotion and awareness activities, diabetes education and training, integration of evidence based programs in chronic disease management, and collaborative partnerships between community-based organizations and health care providers and professionals in local settings. In order to ensure improved outcomes and maximum impact, all strategies must be targeted at those most vulnerable, and experiencing the greatest disparities in access and with the poorest diabetes outcomes. Individuals with no health insurance or underinsured should be highly considered.

II. BACKGROUND

Office of Minority and Multicultural Health

In September 1990, the New Jersey Office of Minority Health was established by an Executive Order. In January 1992, formal legislation creating the office was passed and signed into law. On August 8, 2001, Bill A2204 was signed, renaming the Office of Minority Health to the Office of Minority and Multicultural Health (OMMH). The amended bill strengthens the activities and increases the functions of the Office in several ways, including the following:

- Clarifies that the populations OMMH serves include both racial and ethnic minorities, and that its ultimate goal is to eliminate health disparities.
- Enhances the Office's community outreach by allowing the Office to award grants to community-based programs.

The mission of the OMMH is to foster high quality programs and policies that help all racial and ethnic populations in New Jersey achieve optimal health achieve optimal health at all stages of life. OMMH is committed to helping people in these diverse communities live longer, healthier lives and to leading the effort to reduce – and eventually eliminate – health disparities in New Jersey.

Specific activities of the OMMH include, but are not limited to:

- Raising awareness of health disparities and their impact on racial and ethnic communities in New Jersey.
- Promoting community health outreach and education through partnership with community based organizations, including faith-based groups.

In March 2007, the New Jersey Department of Health and Senior Services (NJDHSS) released its ***Strategic Plan to Eliminate Health Disparities*** as per P.L. 2004 C. 137 (www.nj.gov/health/omh/plan). The Disparities Plan presents data on the status of disparities in 13 medical priority areas in NJ, among them diabetes, summarizes NJDHSS initiatives which address these disparities, specifies goals, with an action plan and

outcome measures for closing existing gaps, and establishes initiatives to strengthen NJDHSS infrastructure relative to (1) improving and standardizing race/ethnicity data collection and reporting procedures, (2) increasing and improving cultural competency and language access initiatives, (3) increasing the number of minorities in health professions, and (4) building community partnerships and capacity to conduct large scale outreach initiatives.

Diabetes Health Disparities in New Jersey

In New Jersey, about 2,500 deaths each year are due to diabetes. The age-adjusted death rate due to diabetes has remained around 28 per 100,000 population throughout the decade. The rate among males is higher than the rate among females for each racial/ethnic group. The rate among African Americans is at least double the rate of any other racial/ethnic group. As consistent with the nationwide data, there are dramatic differences in the incidence, prevalence, morbidity and mortality related to diabetes among racial and ethnic minority populations compared to Caucasians.

Diabetes is the sixth leading cause of death in New Jersey overall and in the United States. The rate among New Jerseyans is consistently about 10% higher than the US rate. Diabetes ranks higher as a leading cause of death among African Americans, Asians, and Hispanics compared to Whites. It is the third leading cause of death among Blacks, fourth among Hispanics and Asians, and fifth among Whites (2006 State Health Assessment Data).

The 2009 New Jersey Behavioral Risk Factors Survey (BRFSS) estimates the prevalence of diabetes in New Jersey is about 9%, with approximately 800,000 individuals suffering from the disease statewide. Within racial/ethnic group African Americans have significantly higher prevalence with 13% reporting having received a diabetes diagnosis. Hispanics and Asians also have slightly higher prevalence of diabetes compared to Whites.

About 33% of persons treated for End-Stage Renal Disease (ESRD) statewide have a primary diagnosis of diabetes according to the Trans-Atlantic Renal Council (TARC)

Report of 2009. Though ESRD rates have declined in recent years, African Americans are still significantly more likely to develop ESRD compared to other racial/ethnic groups.

The OMMH Reducing Diabetes Disparities Grant program is intended to help close the gaps described above. Due to the numerous comorbidities associated with diabetes such as obesity, heart disease and kidney disease, and the lifestyle behaviors which impact its progression, it is essential that persons at risk or living with the disease are not only aware of their risk and/or condition, but also equipped with the information, self-management skills, and access to health care services which are required to manage it.

Division of Family Health Services

The OMMH Community Health Mobilization Grant Program: Reducing Diabetes Disparities is administered in collaboration with the Diabetes Prevention and Control Program (DPCP) within the Division of Family Health Services. The Diabetes Prevention and Control Program seeks to reduce the impact of diabetes in New Jersey by:

- Increasing awareness of diabetes and its complications;
- Improving the quality of diabetes care and access to care;
- Developing partnerships and increasing community involvement to address diabetes issues; and
- Utilizing data to better apply resources and improve health outcomes.

DPCP program staff will serve as program managers for the Diabetes Grant Program. DPCP will administer the program and coordinate directly with awardees to ensure that grant specifications are successfully implemented.

III. AWARD INFORMATION

Funds available for this initiative are contingent upon state appropriation. Approximately $500,000 may be available in FY 2011-2012 to support five diabetes projects. Individual awards will not exceed $100,000 per year for three years. Funding estimates may vary. The period for this demonstration project will be from July 1, 2011 through June 30, 2014. It is expected that awards will begin on or about July 1, 2011.

IV. PROJECT FOCUS

Prospective applicants are expected to identify and target programming in a high risk, disadvantaged racial/ethnic minority community within a specific municipality or defined neighborhood(s). The targeted community should include a population that equals or exceeds the percentage of the targeted racial/ethnic community statewide. While the project must primarily serve residents of the specified community, the target community may also include users of services in the surrounding geographic areas.

Applicants shall have the experience and capacity of linking with Federally Qualified Health and Migrant Centers to support early diagnosis and better management of diabetes. The project seeks to improve overall diabetes outcomes in racial/ethnic minority communities which are at higher risk due to diabetes. Through raising awareness using coordinated outreach strategies, facilitating clinical encounters including diabetes screenings, education and self management sessions, the activities of this grant are expected to prevent unnecessary hospitalizations and deaths caused by diabetes.

Community and faith-based minority serving organizations applying for this grant are expected to demonstrate existing partnerships with Federally Qualified Health and Migrant Centers in order to increase referrals for clients identified as high risk through the American Diabetes Association Risk Test (ADART) or to link clients previously diagnosed with diabetes who are not receiving medical care with services.

Applicants must cite available data using the New Jersey State Health Assessment Data Query System (NJSHAD), Healthy New Jersey 2010 indicators, the New Jersey Department of Health and Senior Services' Plan to Eliminate Health Disparities (www.state.nj.us/health/chs and www.state.nj.us/health/omh), or other reliable data sources which can demonstrate the burden of diabetes on the targeted community.

A multifaceted strategy is employed to achieve improved outcomes in the targeted communities. The essential components of the intervention include community engagement, education and outreach, facilitating linkages to health care services, and tracking and evaluation of individual and programmatic outcomes.

Defining Health Disparities Initiatives

OMMH defines a successful disparity initiative as a programmatic activity that includes but is not limited to the following strategies:

- Data collection/tracking of racial/ethnic data and primary language spoken;
- Demonstration of cultural competency and language access services;
- Improved access to quality of care;
- Built and maintained community partnerships;
- Evaluation.

Community engagement, education and outreach

Coordinated health education and promotion activities shall include, but are not limited to the following:

- Identification and assessment of diabetes risk levels among minority populations by administering at least 500 ADART tests;
- Provision of diabetes education and self-management training to at risk community members using the Chronic Disease Self-Management Program (CDSMP) of Stanford University as well as other methods;
- Provide education on nutrition, cooking and physical activities; and
- Conduct 2 peer leaders CDSMP workshops per year within the targeted community. CDSMP is described below in greater detail.

Linkages to routine health care services

The grantee will facilitate a strategy for establishing or improving routine health care services for targeted community members. Activities shall include but are not limited to:

- Referrals for clinical screening of high risk individuals identified through ADART screening to Federally Qualified Health and Migrant Centers or other professional health care services;
- Education on required routing testing related to diabetes-management;

- Scheduling appointments and maintaining communication with clients and health care professionals to ensure that essential information is shared and understood;
- Identification of potential alternative methods for facilitating routine follow-up outside of traditional health care settings;
- Provide education on nutrition and healthy cooking; and
- Offer physical activity classes.

Evaluation

In order to measure and ensure that the intended impact is being achieved, grantees must establish a system for tracking identification of new diabetes cases, referrals for clinical care, and the overall health status of diagnosed diabetics. In depth data shall be compiled on a subset of all recipients of health care serves as a result of this grant. Activities to achieve this goal shall include but are not limited to:

- Keeping records on status of referrals of diagnosed diabetics including demographic data such as age at diagnosis, gender, race/ethnicity, primary language spoken.
- Track individual diabetes management activities such as number of annual clinical screenings for cholesterol (LDL-C) and glucose (HbA1C), and number and frequency of eye and foot exams.
- Collect per client annual data on height and weight for Body Mass Index (BMI), and blood pressure at initial visit, 30 day and 90 day intervals from onset of the intervention; as well as initial and subsequent HbA1C levels, and number of diabetes education activities attended; and
- Development and maintenance of an evaluation module to capture and report all data related to implementation of the initiative.

Chronic Disease Self-Management Program

The CDSMP was developed by the School of Medicine at Stanford University in California and is recognized internationally as a premiere, evidence-based health promotion and disease prevention program. In one of many studies that have validated the impact of the program, Stanford University and Kaiser Permanente documented the benefits of CDSMP in 1996. Researchers interviewed more than 1,000 people with heart disease, lung disease, stroke or arthritis in a randomized, controlled test of the program

and followed them for up to three years. Compared to individuals who did not enroll, many participants in the CDSMP experienced major improvements in their overall health. They reported improved ability to exercise, manage their symptoms, and talk with their healthcare professional. Program participants also reported spending fewer days in the hospital.

The OMMH in collaboration with the NJDHSS Division of Aging and Community Services (DACS) has been providing funding to expand the CDSMP in minority communities for four years. CDSMP workshops are held once a week for six weeks in community settings. Individuals completing the program are taught by trained peer leaders. Workshop participants learn strategies for managing symptoms, working with health care professionals, setting weekly goals, problem-solving, relaxing, eating right and exercising safely and easily.

More information on CDSMP can be found on the Division of Aging and Community Services and/or the Office of Minority and Multicultural Health websites at www.nj.gov/health/omh.

V. ELIGIBLE APPLICANTS

Eligible applicants must be a non-profit community or faith-based minority serving organization with previous or current experience in administering and implementing community health intervention programs targeting minorities in partnership with a Federally Qualified Health and Migrant Center, and with 501(c) 3 status. Hospitals, health care provider organizations, local health departments and Federally Qualified Health and Migrant Centers are not eligible to apply as the lead agency.

Eligible applicants must meet the following criteria (also, see proof of eligibility below):

- Must be located in the target community, have an established record of two or more years of experience operating health education and prevention programs

with demonstrated strong linkages to a local Federally Qualified Health and Migrant Center and to the proposed racial/ethnic minority community.

- Demonstrate a history of providing effective, culturally competent, and linguistically appropriate health-related outreach services to the targeted racial/ethnic communities.

VI. PROOF OF ELIGIBILITY

Applicants **must** answer the following questions and provide documents requested. **Failure to provide required documentation will result in disqualification**. Please attach the requested documents to your State of New Jersey System for Administering Grants Electronically (SAGE) application.

1. Does your organization currently have valid Internal Revenue Services (IRS) 501(c)(3) tax-exempt status? **Attach a copy to your application**.
2. Does your organization have a process for engaging community input? **Attach a description of that process.**

VII. PROJECT REQUIREMENTS

Identification

Community programs will be engaged in activities that facilitate the identification of newly diagnosed cases of diabetes and/or poorly managed diagnosed diabetics.

- Identify individuals at risk for developing diabetes using the American Diabetes Association risk assessment. Develop a mechanism to appropriately refer those individuals to a health care provider (e.g., FQHC).

Outreach, Education & Support

Community programs will be engaged in local outreach efforts to educate the target community about the level of risk in their communities, risk factors for diabetes, strategies for disease management and overall raising awareness of diabetes in the community.

A. Demonstrate understanding and background knowledge of diabetes and how it affects the targeted population, and present effective outreach strategies for addressing the problem.
B. Increase awareness of the diabetes disparity that exists in the local community.
C. Provide culturally competent health/medical materials, including resources for limited English proficiency (LEP) populations, where appropriate, as part of regular educational outreach efforts.
D. Promote existing hot lines, web sites and other health resources (e.g., National Diabetes Education Program) that focus on diabetes.
E. Promote smoking cessation and treatment services.
F. Conduct the CDSMP workshops for clients with diabetes at the project facilities or at other community settings such as churches, community centers, libraries, etc. Technical assistance will be made available through the NJDHSS, DACS and the OMMH.

Link & track and provide Case Management services

Community programs will be engaged in partnerships that facilitate the identification and treatment of community members diagnosed with diabetes. Individual case management will ensure that community members will meet recognized standards of care.

A. Link with Federally Qualified Health and Migrant Centers to enlist the services of appropriately qualified health professional(s) or others who will help clients manage their diabetes. Under the grant, funding can be used to bring in a consultant—e.g., certified diabetes educator (CDE), certified health education specialist (CHES), nurse or other health professional.
B. Provide evidence of effective collaboration with a health care provider (e.g., FQHC/Diabetes Collaborative participant, migrant health center, local health department or hospital or the individual's own health care provider) for referral of participants to appropriate health care services.
C. Obtain consent and provide follow-up contacts to encourage effective diabetes management and control.

D. Establish an electronic referral and follow-up system to allow the tracking of individual participants' progress. The system must include demographic as well as measurable outcomes data. All data collected must comply with the Race and Ethnicity Coding Guidelines for the New Jersey Department of Health and Senior Services and its Grantees of December 2007. This document is available at: www.nj.gov/health/chs/documents/re_coding_standard.pdf.
E. Develop and implement a case management program that will meet diabetes related needs of the target population and/or their families in the identified community.
F. Deliver case management services which can include but are not limited to telephone referrals, document preparation, advocacy, translation, home visits, escorting services, purchasing of supplies, or individualized education sessions.
G. Develop individualized and goal oriented case management plans.
H. Regularly review and document progress in client files.
I. Encourage clients to develop and maintain a personalized diabetes management plan.
J. Provide culturally competent and linguistically appropriate resources.
K. Identify smoking clients and make referrals to the state-sponsored cessation counseling service of the New Jersey Quitline.

Evaluate

Community programs document linkages, services offered and individual outcomes electronically using a coordinated and structured system. Results will be used to evaluate effectiveness of strategies employed to achieve desired and improved diabetes outcomes.

A. Establish a system with collaborating health care providers and clients; do document clinical care visits, test results and other relevant information.
B. Submit a preliminary evaluation plan describing how the program intends to track and document referrals and linkages of patients to the health care partner. The plan shall describe how the applicant will measure effectiveness in improving quality of diabetes care on at least 50 of the intervention's participants.
C. Keep electronic records on status of referrals of diagnosed diabetics, including demographic data such as age at diagnosis, gender, race/ethnicity, and primary

language spoken, in consistency with the Race and Ethnicity Coding Guidelines of the NJDHSS.

D. Track individual diabetes management activities such as number of annual clinical screenings for LDL-C and A1C, and number and frequency of eye and foot exams.

E. Collect per client annual data on height and weight (for BMI), and blood pressure at initial visit, 30 day and 90 day intervals from onset of the intervention; as well as initial and subsequent HbA1C levels, and number of diabetes education activities attended.

F. Report all data related to implementation as required by the parameters of this grant.

G. Complete and submit required statistical report forms quarterly through the New Jersey System for Administering Grants Electronically (SAGE).

VIII. APPLICATION CONTENT OUTLINE

The application must address all components listed below.

- Fully complete all required NJDHSS Health Service Grant Application forms through the New Jersey Department of Health and Senior Services' System for Administering Grants Electronically (SAGE) which can be accessed on the web at https://enterprisegrantapps.state.nj.us/NJSAGE/portal/. If more space is required, you can attach additional electronic files to your SAGE application.
- Applicants must comply with the A-122 cost principles for non-profit organizations. These principles may be found in the following federal Office of Management and Budget web site: http://www.whitehouse.gov/omb/circulars_a122_2004

Agency Overview - 10 Points

A. Provide a brief description of the Applicant's mission, history and programs.

B. Provide a description of the Applicant's experience in providing culturally, ethnically and linguistically appropriate services to the target population, as well as a summary of the impact of those services.

C. Provide a description of current collaborative efforts, if any, with minority community-based organizations and with health care providers in your service area.

D. Provide a list of staff related to this project, including a description of the professional/educational background individual staff to verify appropriateness for providing certain services.

Needs Assessment - 10 Points

A. Discuss the specific barriers and challenges confronting the target community in regard to diabetes. Support the needs assessment statement with an overview of the programs that already exist in the community and conversely, what your program intends to provide that is lacking in the community. Address specifically how your program will fulfill that need.

Objectives - 20 Points

A. State the project mission, objectives and goals. The objectives should be specific, realistic, time-phased, and measurable. Objectives should focus on the projected amount, frequency, duration, and specific timeframe of the proposed intervention and the number of participants to be served.

Methods - 25 Points

A. Provide a detailed description and time-line for major tasks and project activities. Emphasis should be placed on the project's design (addressing required areas: Identify, Educate & Support, Link & Track and Evaluate) and relationship between objectives and planned intervention(s). The proposed intervention(s) must relate to the needs of the community to be served, exhibit cultural competency, be medically sound, demonstrate a link to quality health care, have the potential to affect outcomes in the identified area of disparity, demonstrate a potential to leverage additional public or private resources, and show a capacity for replication throughout the state. Information about the intervention may include the role and participation of families, peers, health care providers and other support systems needed to achieve effective outcomes.

B. Describe if your organization already has Peer Leaders from the CDSMP training workshops funded by OMMH in partnership with the NJDHSS, DACS in previous years; or if your organization will be contracting or training their own personnel; and the function of the CDSMP's Peer Leaders in your methodology. (Please refer to **Project Focus**, *Chronic Disease Self-Management Program, in Section IV* of this document.)

Evaluation - 25 Points

A. Submit a plan on how the project will be monitored and evaluated to determine whether project objectives have been met. Clearly show how progress toward attaining objectives and monitoring activities during the project year will be measured. Describe appropriate process and outcome measures. The plan should also describe how information and data will be collected, analyzed and used. If the Stanford Model is implemented, the evaluation plan shall also include their standardized patient surveys (pre/post), quality care interviews and other measurable processes. How frequencies of quality improvement measures, such self-management education, foot checks, eye exams and A1Cs are going to be recorded and compared for each individual patient and within a sample group of at least 50 individuals. The plan shall describe how the applicant will measure effectiveness in improving quality of diabetes care on at least 50 the intervention's participants.

Budget - 10 Points

A. Budget costs must be reasonable and appropriate for the direct provision of services to the target population. The budget costs must be specific and tied to the project objectives and planned interventions and in compliance with OMB Circular A-122. ***Funds may not be used to replace existing program costs.***

IX. APPLICATION REVIEW AND AWARD SCHEDULE

Friday, February 11, 2011	Release RFA
Thursday, March 3, 2011	Technical Assistance Meeting
Friday, March 18, 2011	Letter of Intent is due to OMMH
Friday, April 15, 2011	Applications due to OMMH
Friday, April 22, 2011	Applications' review for completion
Monday, April 25 – Friday, May 4, 2011	Applications' review/determination
Monday, May 9- Friday, May 20, 2011	Notification of review determination
Monday, May 23 – Friday, June 10, 2011	Notice of Grant Award
July 1, 2011	Projects Begin

X. SUBMISSION OF APPLICATIONS

Grant applications and attachments must be submitted through the New Jersey Department of Health and Senior Services' System for Administering Grants Electronically (SAGE) by **Friday, April 15, 2011, at 4:00 p.m. EST.** Paper submissions of the proposal document or any attached documentation will not be accepted either through regular mail, fax or email. No extensions will be granted and the SAGE System will automatically reject all late applications.

Applying for OMMH Grants Online through SAGE

The Department of Health and Senior Services (NJDHSS) requires all grant applications to be submitted electronically through our System for Administering Grants Electronically (SAGE). There are two tracks for grantees applying through SAGE. The first track is for those applicants who have never registered or applied for grants electronically with the Department of Health and Senior Services or with another department using SAGE. The second track is for grantees that are registered and/or have already applied for grants through NJDHSS or with another department.

New Users

1. All individuals using SAGE must be registered in SAGE.
2. You only register as a user one time.

3. The authorized official for your agency will need to approve you as a user.
4. The authorized official must be validated by the NJDHSS Administrator before other actions can be taken. Contact your Program Management Officer (PMO).
5. Authorized officials can change user approval levels for personnel within their organization.
6. All organization applying for grants must be registered in SAGE, have a federal employer identification number, and a DUN number. Contact your Grants Manager Officer (GMO) or NJDHSS Administrator with questions.
7. Your organization must be made eligible to apply for a grant in order to complete an application. Contact your PMO if you are cannot access the application.
8. To add additional information and documents required to be submitted with your application, go to the Miscellaneous Attachments found in the application's grant forms.
9. If you know the vendor number and address used for payments by the state, you may enter that data. If you are not sure or have never done business with the state contact your GMO.
10. If you have any problems, or questions, with the grant application you should contact your PMO or GMO.

Current Users

1. Each year your organization must be made eligible to apply for a grant in order to complete an application. If you cannot access the grant application you should contact your PMO.
2. Most information should be brought over from your prior year's grant award. Be sure to make necessary updates and changes in all forms and certifications.

Completing and Submitting Your Grant Application in SAGE

1. Once you are approved by SAGE, go to www.sage.nj.gov, log on using the user name and password you specified at time of registration.

2. Once logged in, on left side of screen see box "MY DOCUMENTS"
   - Click on "OMMH Grants."
   - Click on "Create New OMMH Grants application"

- Agree to NJDHSS Terms and Conditions.

3. On right side of screen, go to box titled “FORMS”, click on file marked “Grant Application Forms”. You will see the following forms listed:
   - NJDHSS Organization Information Review Page
   - Application Summary
   - Project Location
   - Local Aid & Legislative Districts
   - Statement of Local Governmental Public Health Partnership
   - Needs and Objectives of Projects
   - Method(s) and Evaluation of Project
   - Schedule A – Full Time Personnel Costs
   - Schedule A – Full Time Personnel Costs Justification
   - Schedule A – Part Time Personnel Costs
   - Schedule A – Part Time Personnel Costs Justification
   - Schedule A – Personnel Costs – No Fringe
   - Schedule A – Personnel Justification
   - Schedule B – Consultant Services Costs
   - Schedule B – Consultant Services Justification
   - Schedule C – Other Cost Categories
   - Funds and Program Income from Other Sources Related to this Application
   - Cost Summary
   - Schedule D – Officers and Directors List
   - Schedule G – Certification Regarding Debarment and Suspension
   - Schedule H – Certification Regarding Lobbying
   - Schedule I – Certification Sheet
   - Schedule J – Agency Minority Profile
   - Schedule K – Certification Regarding Environmental Tobacco Smoke
   - Required Attachments
   - Miscellaneous Attachments

IMPORTANT: Click 'Save' when you complete each form and go to 'next' or back to main menu (which will show application in process.)

- NJDHSS Organization Information Review Page This is the cover page for your grant application and includes contact information for Agency's principal contacts (including Attorney name and agency contact) and agency's fiscal year end.
- Fields with an * next to them must be completed. Review all information and complete the sections that apply, or answer 'N/A'. When complete, check the box at the bottom of the page click the **SAVE** button.
  - Note if agency is licensed by the state for facility, services or personnel
    - If yes, attach copy of agency license to "Miscellaneous Attachments" with the title ***Attachment 1-A: Agency License***, if this does not apply, click 'no'.
  - Check accounting system type
  - Check cost principles
  - Check Affirmative action plan
  - Note Agency Type (private non-profit, etc).
    - Certify that the information provided is correct and provide necessary documentation as attachment. Attach proof of non-profit status as ***Attachment 1-B*** in Miscellaneous Attachments.
- **Agency Overview**
  - Summarize your Agency Overview in a written narrative up to 2 pages long, double-spaced 12 point font, and upload as ***Attachment 2*** under Miscellaneous Attachments. (Refer to Section VIII Application Content Outline)

Click save and proceed to the next page by clicking the **NEXT** button

- **Application Summary**
  - Answer 'yes' or 'no' to two Board of Director questions
  - Select payment plan as 'cost reimbursement'
  - Provide grantee contact information

- Provide Federal tax id
- Provide NJ vendor number
- Certificate of need – select 'not required'
- Political subdivision covered by NJ Civil Service Merit System (yes or no)
- Grant funds used to replace other funds – NO
- Name of NJDHSS Program Manager(s): Jose A. Gonzalez/LorieAnn Wilkerson-Leconte
- Type of Request (select 'New')
- Project period and Budget period: July 1, 2011 – June 30 2012
- Funds requested from state: (Level 3 = $100,000) Funds required from other sources = $0.

Click save and proceed to the next page by clicking the **NEXT** button

- **Statement of Local Governmental Public Health Partnership**
  - Approval or support statement from Local Government Public Health Officer (HO) is required.
  - ☑ "As the authorized official I have reviewed and discussed the proposed grant application with the local health officer and this makes the following certified statement:"
  - Fill our HO's contact information and add statement (Please upload-add the HO statement letter as ***Attachment 3*** under Miscellaneous Attachments in this application.)
  - Click save and proceed to the next page by clicking the **NEXT** button

Local Aid & Legislative Districts (complete), click save and proceed to the next page by clicking the **NEXT** button

Needs and Objectives of Projects (and Cost Summary) In addition to the two designated sections of this page ('Assessment of Needs' and 'Objectives'), applicants may include up to 5 pages, double-spaced 12 point font – upload add as ***Attachment 4*** under Miscellaneous Attachments.)

Section 1: Assessment of Need

- Target population at risk for developing diabetes and with diagnosed diabetes: Age, Gender, Race/Ethnicity, County, City and/or Geographical Location, Income, and other socio-economic characteristics
- Need for your Diabetes Intervention Project in the described geographic area
- Identify number of sites where Project will operate
- State if your program is being offered in a language other than English, identify language(s)
- Current/past experience in developing and operating ;
- Discuss the specific barriers and challenges confronting the target community in regard to diabetes. Support the needs assessment statement with an overview of the programs that already exist in the community and conversely, what your program intends to provide that is lacking in the community. Address specifically how your program will fulfill that need.
- Identify any additional funding being used by the agency to support this application (this includes grants received for this purpose) (Refer to Section VIII Application Content Outline)

Section 2: Objectives of Project: (Refer to Section VIII Application Content Outline)

- State **SMART objectives:**
  1. Specific – Objectives should specify what they want to achieve.
  2. Measurable – You should be able to measure whether you are meeting the objectives or not.
  3. Achievable - Are the objectives you set, achievable and attainable?
  4. Realistic – Can you realistically achieve the objectives with the resources you have?
  5. Time – When do you want to achieve the set objectives?

- **Methods and Evaluation of Project** List your methods or activities in line with your objectives and explain your Evaluation, and proceed to the next page by

clicking the **NEXT** button. (Refer to Section VII Project Requirements and Section VIII Application Content Outline). Also applicants may include up to 5 pages of Methods and Evaluation, double-spaced 12 point font – upload add as ***Attachment 5*** under Miscellaneous Attachments.

- **Schedule A (3 Forms: Full Time, Part Time, Personnel Cost – with Fringe** Complete forms and click save and proceed to the next page by clicking the **NEXT** button

- **Schedule B Consultant Services Costs** You must answer 'Do consultant services demonstrate a true employer/non-employee relationship as per IRS regulations?' Select 'Yes" click save, and proceed to the next page by clicking the **NEXT** button

- **Schedule C Other Cost Categories**– Include other costs and click save, and proceed to the next page by clicking the **NEXT** button

- **Funds and Program Income from Other Sources Related to this Application** Save as blank or complete if you are receiving other funds to implement this proposed diabetes intervention, and include total amount of funding support.

- **Cost Summary** Put cost on Needs and Objectives Form (see instructions above) At the bottom of this page, you must answer 'Do you have an established indirect cost rate?' If yes, attach copy of policy or answer no. click save, and proceed to the next page by clicking the **NEXT** button

- **Schedule D Officers and Directors List** (Complete for Officers and Directors), click save, and proceed to the next page by clicking the **NEXT** button)

- **Schedule G Certification Regarding Debarment and Suspension** (Complete), click save, and proceed to the next page by clicking the **NEXT** button)

- **Schedule H Certification Regarding Lobbying** (complete, click save, and proceed to the next page by clicking the **NEXT** button)

- **Schedule I Certification Sheet** (answer yes or N/A as it applies for each statement), click save, and proceed to the next page by clicking the **NEXT** button

- **Schedule J Agency Minority Profile** (Complete, click save, and proceed to the next page by clicking the **NEXT** button)

- **Schedule K Certification Regarding Tobacco Smoke** (Complete), click save, and proceed to the next page by clicking the **NEXT** button)

- **Required Attachments**
  - If applicable, click on NJ Charities Registration and Proof of Non Profit Status [501(c) (3)] to complete.
  - All others, leave blank, click save, and proceed to the next page by clicking the **NEXT** button

- **Miscellaneous Attachments - THESE DOCUMENTS ARE REQUIRED**
  - **Information on the Project Personnel** (Upload as an attachment the Professional Resumes of the Project Director and the rest of personnel, if available. ***Attachment 6***)

NOTE: ALL MISCELLANEOUS ATTACHMENTS MUST BE COMPLETED OR APPLICATION WILL NOT BE CONSIDERED. After completing all forms, return to main menu, click on view Full OMMH Grant, click 'check for errors' under Management Activities (under Administrative Links), when all errors are corrected, save full application as pdf file, view pdf application, save to your computer and print copy for your files.

In status management box, click 'Change Status' and application will be updated from 'application in process' to 'Application Submitted'. If any forms are incomplete, you will see an error message with details on missing information.

IMPORTANT REMINDER:

All OMMH Grants must be submitted on SAGE by 4:00 pm, Friday, April 15, 2011.

GMO- Bill Jaeger, William.Jaeger@doh.state.nj.us, 609 633-6067
PMO – Jose A. Gonzalez, Jose.Gonzalez@doh.state.nj.us, 609-292-6962
PMO - LorieAnn Wilkerson-Leconte, LorieAnn.Wilkerson-Leconte@doh.state.nj.us, 609-341-5076

XI. TECHNICAL ASSISTANCE

All applicants are expected to attend the RFA technical assistance meeting on Thursday, March 3, 2011, 10:00 a.m. to noon. For further information please contact Mr. Jose A. Gonzalez at 609-292-6962 or at *Jose.Gonzalez@doh.state.nj.us*. More information will follow on the OMMH website at www.nj.gov/health/omh.